Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SURGINSITE SOUTHEAST TEXAS
945 MCKINNEY AVE
HOUSTON TX 77002

Respondent Name
Hartford Fire Insurance Co

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-0025-01

MFDR Date Received
September 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: None submitted with DWC060

Amount in Dispute: $12,323.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that the bills reference in this MDR have been sent for reprocessing to our bill review vendor. Per their advisement, the bill as it stands was paid appropriately. If the provider would like to revise bill and resend it as a reconsideration, it will be reviewed again to determine if an additional allowance would be recommended. Per Medicare and Texas Workers' Compensation guidelines, ASCs must bill on the CMS 1500 claim form and use CPT and/or HCPCs, when billed for facility services rendered."

Response Submitted by: Gallagher Basset Services, Inc. 6750 West Loop South, Suite 300, Bellaire, TX 77401

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 13, December 6, and December 13, 2011	Ambulatory Surgical Center Services	$12,323.28	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.492, titled *Ambulatory Surgical Center Fee Guideline*, sets out the reimbursement guidelines for ambulatory surgical centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 2, 2011

- 16 (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
- 12 (125) SUBMISSION/BILLING ERROR(S).
- BL TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

Explanation of benefits dated January 12, 2012

- 16 (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
- 12 (125) SUBMISSION/BILLING ERROR(S).
- BL TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

Explanation of benefits dated February 6, 2012

- 16 (16) CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION.
- 12 (125) SUBMISSION/BILLING ERROR(S).
- BL TO AVOID DUPLICATE BILL DENIAL, FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to services performed in an ambulatory surgical center with reimbursement subject to the provisions of 28 Texas Administrative Code §134.402,(d) which requires that, "For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided..."

2. The carrier denied the claim with the following reason codes, 16 (16) "CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION", and 12 (125) "SUBMISSION/BILLING ERROR(S)". Review of the submitted documentation finds the claim for the disputed services was not submitted on CMS 1500 form as required by 28 TAC §134.402(d). The Division finds the Carriers' denial is supported.
3. The requestors' use of Place of Service Code "22" on DWC060 is not supported. This facility has a taxonomy code of 261QM1300X (Ambulatory Surgical Center) linked to the National Provider Identifier 1922301480 shown on the claim. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 25, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC

Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.